

ATTORNEY OR PARTY WITHOUT ATTORNEY ( <i>Name, State Bar number, and address</i> ):   TELEPHONE NO. ( <i>Optional</i> ): FAX NO. ( <i>Optional</i> ): E-MAIL ADDRESS ( <i>Optional</i> ): ATTORNEY FOR ( <i>Name</i> ):	<b>FOR COURT USE ONLY</b>
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF</b> STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
CHILD'S NAME:	
<b>OPPOSITION TO APPLICATION FOR ORDER FOR AUTHORIZATION TO ADMINISTER PSYCHOTROPIC MEDICATION—JUVENILE</b>	CASE NUMBER:

(This form must be returned to the court, all parties, and all attorneys of record within two court days of notice of the *Application for Authorization*.)

1. I, \_\_\_\_\_, oppose the application because:

2. I am ☐ a party.  
☐ an attorney for (*name*):  
☐ other (*specify*):

Date:



(SIGNATURE)